



New Patient Information Form (CHILD < 16yr)

We are committed to providing our patients with the best care. To do this it is essential that your medical records are up to date and accurate. Could you please assist us by completing the following?

CONSENT FOR CONTACT [ ] YES [ ] NO

Form with fields: A/c No, Doctor, Date, Surname, First Name, Date of Birth, Medicare number, Emergency Contact, Next of Kin.

To assist with health initiatives – Does your child identify as being of Aboriginal and/or Torres Strait Islander descent?

[ ] Yes [ ] No

Place of Birth - \_\_\_\_\_ Cultural Background/Ethnicity \_\_\_\_\_

Health History - Does your child have?

[ ] Medical Problems \_\_\_\_\_

In the past has your child had?

[ ] Medical Problems/ Past Operations \_\_\_\_\_

Is your child on any medications? Please list below, with doses:

Blank line for listing medications and doses.

Does your child have any allergies or are they sensitive to any medications or dressings?

[ ] Yes (If yes please list below) [ ] No

Children’s Immunisations - Are your child’s immunisations up to date? [ ] Yes [ ] No

Family History - Have any members of the child’s family had any of the following?

[ ] Diabetes \_\_\_\_\_ [ ] Asthma \_\_\_\_\_

[ ] Heart Disease \_\_\_\_\_ [ ] Mental illness \_\_\_\_\_

[ ] Cancer \_\_\_\_\_

[ ] Other \_\_\_\_\_

Reminder Systems:

- The practice routinely sends SMS appointment reminders as well as for results and recalls.

Please tick the box if you are happy to receive these: [ ] Yes [ ] No